Special Commission on the Health Care Payment System

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TO: Members of the Special Commission on Health Care Payment System
FROM: Michael Bailit
DATE: February 13, 2009
RE: Stakeholder Input

Introduction

During the two weeks preceding the Special Commission's February 13th meeting, on your behalf, Commissioner Iselin, Secretary Kirwan's staff, including Glen Shor, Kelly Driscoll, and Candace Reddy, and I met with a range of stakeholder groups. The purpose of these meetings was to:

- inform the stakeholders about the Special Commission, including its origins, scope and timeline;
- describe the process by which the Special Commission seeks to engage stakeholders, and solicit their input at key junctures in the Special Commission's work;
- review the models to be reviewed by the Special Commission, and
- solicit feedback on the draft payment reform principles discussed by the Special Commission during its January 16, 2009 meeting.

We have met with the following stakeholder groups:

- physicians: specialty societies and large independent physician groups;
- physicians: groups affiliated with hospitals;
- hospitals: community hospitals;
- hospitals: teaching hospitals and large safety net hospitals;
- consumer advocates;
- organized labor groups;
- health plans, and
- community health centers.

In addition, we have consulted with the Executive Director of the Commonwealth Health Insurance Connector and briefed the Cost Containment Committee of the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board. Finally, we have scheduled future meetings with a group of employer representatives and with representatives of EOHHS and its agencies.

General Observations

All of the stakeholder groups to which we extended invitations to engage in discussion of the Special Commission's work were eager to participate, and many expressed appreciation for the opportunity to help inform the Special Commission's work. We spent the majority of each meeting discussing the draft principles. The stakeholders understood that the principles are intended to define a beginning framework for the Special Commission's work to develop recommendations for changing how payment is made for health care in Massachusetts. They therefore approached the task with thoughtfulness. Understandably, the different groups voiced varying perspectives, although there were some themes that were not specific to just one type of stakeholder.

There were a few key points of understanding that we took from these meetings:

1. It became readily apparent in the conversations that terminology was at times an impediment, as simple terms often carried different meanings for different groups. On a couple of occasions stakeholders suggested the development of a glossary of terms in order to help avert misunderstanding.

2. Stakeholders all recognized the importance of the work – almost every individual agreed that payment reform was critical. They also, however, realized that a) payment reform by itself would be insufficient to address all of the health care cost drivers, and b) change will be extraordinarily difficult, and is not guaranteed to succeed.

3. A few stakeholders recommended that the principles be accompanied by a vision statement that specifies the outcomes that are being sought through payment reform (e.g., improved patient safety, reduced variation in care delivery, etc.).

4. While many feel that better integration of providers will produce better value, there is disagreement as to whether real or virtual integration will be necessary to respond to potential changes in payment and realize improvements in efficiency, continuity and outcomes.

5. The stakeholders affirmed the notion that broad stakeholder involvement in payment system design will be essential to achieving success.

<u>Recommendations Regarding the Draft Principles</u>
There were a number of valuable recommendations made to improve upon the principles. Some of the recommendation addressed the rewording of existing principles, while others introduced new concepts. This section of the report highlights some of the new concepts that were suggested and which I recommend the Special Commission consider:

1. No one payment model will work for all providers or in all regions of the Commonwealth due to the heterogeneity of the delivery system.
2. Payment reform must address the problem of a shortage of primary care physicians.
3. Payment reform should seek to balance payments for cognitive, preventive chronic and interventional care, and be sensitive to the current cross-subsidization occurring within provider organizations as a result of the lack of balance.
4. Implementation should be phased with time and resources dedicated to evaluation, identification of unanticipated consequences, and mid-course corrections.
5. Payment methodologies should be transparent to all, including patients and providers.
6. Payment reform must be designed with an awareness of the interactive effective of payment model with delivery system organization and with health benefit design.
7. Risk adjustment must contemplate not only differences in health status, but in socio-economic status, since lower income groups tend to have lower levels of adherence to clinical instruction.

Based on this and other input, proposed revisions to the principles were drafted for Special Commission member review and feedback.

We are scheduled for a second round of meetings with each of the same groups following the Special Commission's fifth meeting, and I will report back to the Special Commission again with stakeholder input at the start of the Special Commission's sixth meeting.